BlueCross BlueShield of Delaware
A CareFirst Company

Blue Cross Blue Shield of Delaware and CareFirst, Inc., are independent licensees of the Blue Cross and Blue Shield Association.

GROUP NAME ______ GROUP # ______

451-HC-015 (rev. 4/02)

STATE OF DELAWARE APPLICATION FOR COVERAGE

FOR STATE OF DELAWARE USE ONLY

Name	Phone	Date	Package	Contact	Dept./Agency

A. REASON FOR APPLICATION (check all that apply). Please print legibly.

☐ New coverage
☐ Change coverage
☐ Information change
☐ Refuse coverage *(see Section E)*

ADD DEPENDENTS DUE TO:
☐ Marriage ☐ Non-voluntary coverage loss
☐ Birth ☐ Other
☐ Adoption/Guardianship
Date of event checked:

CANCEL DEPENDENTS DUE TO:
☐ Divorce ☐ Death
☐ Over age ☐ Other
☐ No longer dependent
Date of event checked:

REINSTATE COVERAGE DUE TO:
☐ Rehire ☐ Administrative error
☐ Return from leave ☐ Other
☐ Return from layoff
Date of event checked:

B. PERSONAL INFORMATION

☐ Male ☐ Female ☐ Retiree ☐ Surviving spouse ☐ Non-employee	Date of Hire/Retirement (month, day, year)	Social Security Number	Agency or School District

Last Name	First Name	M.I.	Date of Birth (month, day, year)	Home Phone (include area code)	Business Phone (include area code)

Street Address	City	State	Zip Code

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: ☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE:

☐ Basic ☐ Blue Care (IPA) *(see Section D)* ☐ First State ☐ Comprehensive PPO ☐ Special Medicfill

☐ I AM 65 OR OLDER. ☐ MY SPOUSE IS 65 OR OVER; I AM A FULLTIME EMPLOYEE.

MEDICARE INFORMATION:

Applicant's Medicare #: ______

Part A Effective Date: ______

Part B Effective Date: ______

D. ELIGIBLE DEPENDENTS TO BE COVERED / PRIMARY CARE PHYSICIAN SELECTION

If you choose Blue Care (IPA) coverage, you MUST select a primary care physician (PCP) for yourself, spouse and all eligible dependents
If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.

Name of Your Primary Care Physician	Physician's ID Number	Is this your current physician? ☐ YES ☐ NO

	First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date	Social Security Number	Primary Care Physician	Physician's ID Number	Current physician?
☐ Add ☐ Cancel	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Spouse's Social Security Number	Spouse's Primary Care Physician	Physician's ID Number	Spouse's current physician? ☐ Y ☐ N
☐ Add ☐ Cancel	Dependent's First Name ☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐ Y ☐ N
☐ Add ☐ Cancel	Dependent's First Name ☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐ Y ☐ N
☐ Add ☐ Cancel	Dependent's First Name ☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐ Y ☐ N

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? ☐ I am ☐ My spouse ☐ My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer below:	Name and Location of Other Insurance Company	Transferring your coverage from another Blue Cross Blue Shield contract? ☐ Y ☐ N

F. TERMS OF AGREEMENT

I understand that: 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Blue Cross Blue Shield of Delaware (BCBSD). **2)** I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. **3)** I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to BCBSD, with the understanding that payment will not be complete until actually received. **4)** I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis, treatment or other health care services they render to me or my covered dependents to BCBSD or its designee for purposes reasonably related to this contract. **5)** I, on behalf of myself and my covered dependents, authorize BCBSD to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law.

I elect not to participate in the State Health Insurance Program.	I have read and do agree to the above terms.	Date
Signature:	Signature:	